STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00092925 and IN00093826 Complaint IN00092925- Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, and F226. Complaint IN00093826-Unsubstantiated due to lack of evidence. Survey dates: July 25, 26, 27, 2011 Facility number: 000167 Provider number: 155266 AIM Number: 100273740 Survey team: Ann Armey, RN Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 8 Medicaid: 57 Other: 9 Total: 74 Sample: 8	F0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of federal and state law. We respectfully request the ISDH accept paper compliance as evidence of compliance with federal requirements for participation in the Medicare and/or Medicaid programs in place of a revisit survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2 Quality review completed on July 28, 2011 by Bev Faulkner, RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record review, the facility failed to ensure residents were free from verbal and mental abuse. This deficiency affected 3 of 8 residents reviewed with allegations of abuse in a sample of 8. (Resident #B, #C, #D,) Findings include: On 7/22/11 at 10:55 a.m., the SSD (Social Service Director) indicated she had received a concern on 6/27/11 from two residents (#B and #C), regarding the way they had been talked to and treated by RN #1. She indicated she had written a concern report and had given it to the Administrator and ADON (Assistant	F0223	**F 223 Free from abuse/involuntaryseclusionalleged deficient practice:** **Residents affected by the alleged deficient practice:** **Three residents (#B, #C and #D) were found to have been affected by the alleged deficiency.** **Every resident is at risk to be affected by this alleged deficient practice:** **The entire staff has been trained by the Staff Development Coordinator and Executive Director on the Abuse Policy, signs of abuse, reporting of abuse, and professionalism (completed**	08/02/2011

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	Director of Nursing). She indicated that on 7/5/11, she received a third complaint about RN #1 from the family of Resident #D. The family member felt RN #1 had been abusive to her sister. Documentation regarding the 6/27/11 and 7/5/11 allegations of mistreatment/abuse were reviewed on 7/25/11 at 2:00 p.m., and indicated the following: A Complaint/Concern Registration Form, dated 6/27/11, indicated on Saturday, 6/25/11, Resident #B reported that RN #1 had "cussed at him" and "did not give him his medication until after 10:00 p.m." The form indicated LPN #2 witnessed the event; and LPN #2 "... doesn't remember what (RN #1's name) said just that she cursed and was angry @ (at) him, and yelled at him." A written statement from RN #1, dated 6/27/11 at 2:15 p.m., indicated she was working Saturday, 6/25/11. The statement indicated, in part, that she and Resident #B agreed to give his medications at 8:15 p.m., after the last smoke break but the resident was not in his room at the designated time, so she took the medications back to the medication cart. The statement indicated around 8:35 p.m., Resident #B demanded his medications.		**8/2/11).** **Every instance of suspected abuse of any kind will be treated appropriately using our Abuse Policy and state guidelines to include immediate suspension pending investigation, notification of the state within 24 hours, notification of corporate compliance entities, and a thorough investigation using the guidelines of state and facility policies.** **Systems to ensure alleged deficient practice does not recur:** **Quarterly reminder training of entire staff on the abuse policy will be conducted by the Executive Director and Social Services.** **Initial training by Social Services on the Abuse Policy with new associates during orientation, Including recognizing abuse, management of tone and perception, and proper reporting.** **Executive Director will manage suspected abuse allegations immediately following state and facility policies.** **Any allegations will be**	

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	"Writer told resident (Resident #B) 'if he would quit acting like an ass I would get him his medication so he could go to bed. Resident proceeded to state to nurse 'yeah I know cause you gotta job to do, so do it.' In response nurse stated 'I have until 10 p.m. to finish what I need to.'..." A second Complaint/Concern Registration Form, dated 6/27/11, indicated RN #1 yelled at Resident #C and threatened to write her up. The report indicated Resident #C felt RN #1 was trying to embarrass her. A third complaint against RN #1, dated 7/5/11, was documented by the ADON. The complaint was from the sister of Resident #D and indicated, in part, that on 7/5/11, RN #1 would not let Resident #D have a soda because she was diabetic. The complaint report indicated Resident #C was upset by the way in which (RN #1's name) told her she couldn't have a soda. She indicated her sister, Resident #D, felt like she was "in jail" and was "afraid...." The complaint report also indicated LPN #2 had called Resident #D's sister at home and told her RN #1 had been "verbally abusive" to Resident #D on multiple occasions. On 7/6/11, LPN #2 was terminated. The		**discussed in Resident Council for the group's approval of our findings and actions on a monthly basis.** **Monitoring to ensure alleged deficient practice does not recur:** **Abuse reporting and follow up actions added to monthly Process Improvement meeting to monitor for trends and completeness.** **Date of Completion: August 2 nd , 2011**	

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	termination form indicated LPN #2 called a family member at home and accused another nurse of verbal abuse. LPN #2 "...did not take this allegation to any manager and she did not follow the procedures outlined in our abuse policies...." On 7/8/11, RN #1 was given a verbal warning indicating "...You will respect the rights of the residents in this facility. You will manage your tone and ensure that the perception is never that you are angry or dismissive or talking down to any one." The corrective action form indicated RN #1 had received training on 7/5/11 and had met with the Administrator, DON, and ADON. On 7/11/11, the investigation of RN #1 was reopened and an initial report was sent to the ISDH. The Suspension Investigation Form, dated 7/12/11, indicated RN #1 was suspended on 7/11/11. The form indicated three residents had made allegations against RN #1 and the Administrator interviewed the residents and they were satisfied with the response to their complaints. The Suspension Form indicated further investigation was initiated by the Division Office and "found that all three residents felt either like they were talked to like a child or demeaned by the tone."			

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The final investigative report, dated 7/15/11, indicated the staff persons comments were inappropriate.

The Termination Notice form indicated RN #1 was terminated on 7/15/11, "... for acting indifferently or rudely toward others...."

On 7/25/11 at 2:30 p.m., the Administrator indicated he should have suspended RN #1 when the allegations were initially received.

The DON (Director of Nursing) indicated, after the allegations were reported, RN #1 worked evenings on the unit where Resident #B, #C, and #D resided. The DON indicated RN #1 worked on 6/28/11, 6/29/11, 6/30/11, 7/1/11, 7/4/11, 7/8/11. 7/9/11 and 7/10/11.

The Abuse Investigation Reporting and Response Policy, undated, provided by the Administrator, was reviewed on 7/25/11 at 3:00 p.m., and indicated: "...Residents must not be subjected to abuse by anyone,...
Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation.
Verbal Abuse: Refers to any use of oral, written, or gestured language that includes

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	disparaging and derogatory terms to residents...regardless of age, ability to comprehend, or disability... If the suspected perpetrator is an associate, the Executive Director shall place the associate on immediate investigatory [sic] suspension while completing the investigation...." This Federal tag relates to Complaint Number IN00092925 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interviews and record review, the facility failed to ensure allegations of mistreatment or abuse were reported to the to the ISDH (Indiana State Department of Health) in accordance with	F0225	**F 225 Investigate/Report Allegations/Individuals** **Residents affected by the a lleged deficient practice: Three residents (#B, #C and #D)**	08/02/2011

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	State law, were reported immediately to the Administrator and failed to ensure residents were protected during abuse investigations. This deficiency affected 3 of 8 residents reviewed with allegations of abuse in a sample of 8. (Resident #B, #C, #D,) Findings include: On 7/22/11 at 10:55 a.m., the SSD (Social Service Director) indicated she had received a concern on 6/27/11 from two residents (#B and #C), regarding the way they had been talked to and treated by RN #1. She indicated she had written a concern report and had given it to the Administrator and ADON (Assistant Director of Nursing). She indicated that on 7/5/11, she received a third complaint about RN #1 from the family of Resident #D. The family member felt RN #1 had been abusive to her sister. Documentation regarding the 6/27/11 and 7/5/11 allegations of abuse were reviewed on 7/25/11 at 2:00 p.m., and indicated the following: A Complaint/Concern Registration Form, dated 6/27/11, indicated on Saturday, 6/25/11, Resident #B reported that RN #1		**were found to have beenaffected by this alleged deficiency.** **Every resident is at risk to be affected by this alleged deficient practice:** **Executive Director and Staff Development C oordinator reeducated entire staff byin-service on reporting (8/2/11) and identifying signs of abuse.** **Executive Director was reeducated by s uperiors on the process and expectationswhen an allegation is made (7/17/11).** **Systems to ensure alleged deficient practice does not recur:- Allegations will be followed up on withinTwo hours of declaration. - Staff members identified in an allegation will be suspended immediately pendinginvestigation.** **A thorough investigation will be conducted by Executive Director or designee followingstate and facility guidelines.** **Staff members found to have abused a resident in any manner will be terminated.** **An initial incident report will be supplied to the ISDH within 24 hours and a follow up completedupon completion of investigation.**	

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	had "cussed at him" and "did not give him his medication until after 10:00 p.m." The form indicated LPN #2 witnessed the event; and LPN #2 "... doesn't remember what (RN #1's name) said just that she cursed and was angry @ (at) him, and yelled at him." A written statement from RN #1, dated 6/27/11 at 2:15 p.m., indicated she was working Saturday, 6/25/11. The statement indicated, in part, that she and Resident #B agreed to give his medications at 8:15 p.m., after the last smoke break but the resident was not in his room at the designated time, so she took the medications back to the medication cart. The statement indicated around 8:35 p.m., Resident #B demanded his medications."Writer told resident (Resident #B) 'if he would quit acting like an ass I would get him his medication so he could go to bed. Resident proceeded to state to nurse 'yeah I know cause you gotta job to do, so do it.' In response nurse stated 'I have until 10 p.m. to finish what I need to.'..." A second Complaint/Concern Registration Form, dated 6/27/11, indicated RN #1 yelled at Resident #C and threatened to write her up. The report indicated Resident #C felt RN #1 was trying to		**Staff will have refresher training on the Abuse P olicy quarterly from the Executive Director andSocial Services.** **New associates will have abuse training provided by Social Services as partof their initial orientation before being allowedto work in the facility.** **Monitoring to ensure alleged deficient practice does not recur:** **Abuse reporting and follow up actions added to monthly Process Improvement meeting tomonitor for trends and completeness.Date of Completion: August 2nd , 2011**	

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	embarrass her. A third complaint against RN #1, dated 7/5/11, was documented by the ADON. The complaint was from the sister of Resident #D and indicated, in part, that on 7/5/11, RN #1 would not let Resident #D have a soda because she was diabetic. The complaint report indicated Resident #D was upset by the way in which (RN #1's name) told her she couldn't have a soda. She indicated her sister, Resident #D, felt like she was "in jail" and was "afraid...." The complaint report also indicated, LPN #2, called Resident #D's sister at home and told her RN #1 had been "verbally abusive" to Resident #D on multiple occasions. On 7/6/11, LPN #2 was terminated. The termination form indicated LPN #2 called a family member at home and accused another nurse of verbal abuse. LPN #2 "...did not take this allegation to any manager and she did not follow the procedures outlined in our abuse policies...." On 7/8/11, RN #1 was given a verbal warning indicating "...You will respect the rights of the residents in this facility. You will manage your tone and ensure that the perception is never that you are angry or dismissive or talking down to any one."			

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	The corrective action form indicated RN #1 had received training on 7/5/11 and had met with the Administrator, DON, and ADON. On 7/11/11, the investigation of RN #1 was reopened and an initial report was sent to the ISDH. The Suspension Investigation Form, dated 7/12/11, indicated RN #1 was suspended on 7/11/11. The form indicated three residents had made allegations against RN #1 and the Administrator interviewed the residents and they were satisfied with the response to their complaints. The Suspension Form indicated further investigation was initiated by the Division Office and "found that all three residents felt either like they were talked to like a child or demeaned by the tone." The final investigative report, dated 7/15/11, indicated the staff persons comments were inappropriate. The Termination Notice form indicated RN #1 was terminated on 7/15/11, "... for acting indifferently or rudely toward others...." Although allegations of abuse against RN #1 were received on 6/27/11 and 7/5/11 respectively, there was no documentation the nurse was suspended or that the ISDH			

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	was notified regarding the allegations until 7/11/11 (14 days after the first allegation was reported). On 7/25/11 at 2:30 p.m., the Administrator indicated he should have suspended RN #1 and reported the allegations of abuse to the ISDH when they were initially received. The DON (Director of Nursing) indicated that after the allegations were reported, RN #1 worked evenings on the unit where Resident #B, #C, and #D resided. The DON indicated RN #1 worked on 6/28/11, 6/29/11, 6/30/11, 7/1/11, 7/4/11, 7/8/11. 7/9/11 and 7/10/11. This Federal tag relates to Complaint Number IN00092925 3.1-28(c) 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interviews and record review, the facility failed to ensure their abuse	F0226	**F226 Develop/Implement Abuse/Neglect, Etc Policies**	08/02/2011

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	policies were implemented, in regard to, suspending staff during abuse investigations, reporting allegation of abuse immediately to the Administrator of the facility and reporting allegations of abuse to the ISDH (Indiana State Department of Health) in accordance with State law. This deficiency affected 3 of 8 residents reviewed with allegations of abuse in a sample of 8. (Resident #B, #C, #D,) Findings include: On 7/22/11 at 10:55 a.m., the SSD (Social Service Director) indicated she had received a concern on 6/27/11 from two residents (#B and #C), regarding the way they had been talked to and treated by RN #1. She indicated she had written a concern report and had given it to the Administrator and ADON (Assistant Director of Nursing). She indicated that on 7/5/11, she received a third complaint about RN #1 from the family of Resident #D. The family member felt RN #1 had been abusive to her sister. Documentation regarding the 6/27/11 and 7/5/11 allegations of abuse were reviewed on 7/25/11 at 2:00 p.m., and indicated the following:		**Residents affected by the alleged deficient practice:** **Three residents (#B, #C and #D) were found to have been affected by the alleged deficiency.** **Every resident is at risk to be affected by this alleged deficient practice:** **The entire staff has been trained on the Abuse Policy, signs of abuse, reporting of abuse, and professionalism by the Executive Director and Staff Development Coordinator (completed 8/2/11).** **Every instance of suspected abuse of any kind will be treated appropriately using our Abuse Policy and state guidelines to include immediate suspension pending investigation, notification of the state within 24 hours, notification of corporate compliance entities, and a thorough investigation using the guidelines of state and facility policies.** **Systems to ensure alleged deficient practice does not recur:** **Quarterly reminder training of entire staff**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Complaint/Concern Registration Form, dated 6/27/11, indicated on Saturday, 6/25/11, Resident #B reported that RN #1 had "cussed at him" and "did not give him his medication until after 10:00 p.m." The form indicated LPN #2 witnessed the event; and LPN #2 "... doesn't remember what (RN #1's name) said just that she cursed and was angry @ (at) him, and yelled at him." A written statement from RN #1, dated 6/27/11 at 2:15 p.m., indicated she was working Saturday, 6/25/11. The statement indicated, in part, that she and Resident #B agreed to give his medications at 8:15 p.m., after the last smoke break but the resident was not in his room at the designated time, so she took the medications back to the medication cart. The statement indicated around 8:35 p.m., Resident #B demanded his medications. "Writer told resident (Resident #B) 'if he would quit acting like an ass I would get him his medication so he could go to bed. Resident proceeded to state to nurse 'yeah I know cause you gotta job to do, so do it.' In response nurse stated 'I have until 10 p.m. to finish what I need to.'...." A second Complaint/Concern Registration		**on the abuse policy by the Executive Director and Social Services. Initial training on the Abuse Policy with new associates during orientation, including recognizing abuse, management of tone and perception, and proper reporting will be provided by Social Services. Executive Director will manage suspected abuse allegations immediately following state and facility policies. Monitoring to ensure alleged deficient practice does not recur: Abuse reporting and follow up actions added to monthly Process Improvement meeting to monitor for trends and completeness. Date of Completion: August 2 nd , 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 00 B. WING	07/27/2011

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	Form, dated 6/27/11, indicated RN #1 yelled at Resident #C and threatened to write her up. The report indicated Resident #C felt RN #1 was trying to embarrass her. A third complaint against RN #1, dated 7/5/11, was documented by the ADON. The complaint was from the sister of Resident #D and indicated, in part, that on 7/5/11, RN #1 would not let Resident #D have a soda because she was diabetic. The complaint report indicated Resident #C was upset by the way in which (RN #1's name) told her she couldn't have a soda. She indicated her sister, Resident #D, felt like she was "in jail" and was "afraid...." The complaint report also indicated LPN #2 called Resident #D's sister at home and told her RN #1 had been "verbally abusive" to Resident #D on multiple occasions. On 7/6/11, LPN #2 was terminated. The termination form indicated LPN #2 called a family member at home and accused another nurse of verbal abuse. LPN #2 "...did not take this allegation to any manager and she did not follow the procedures outlined in our abuse policies...." On 7/8/11, RN #1 was given a verbal warning indicating "...You will respect the			

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	rights of the residents in this facility. You will manage your tone and ensure that the perception is never that you are angry or dismissive or talking down to any one." The corrective action form indicated RN #1 had received training on 7/5/11 and had met with the Administrator, DON, and ADON. On 7/11/11, the investigation of RN #1 was reopened and an initial report was sent to the ISDH. The Suspension Investigation Form, dated 7/12/11, indicated RN #1 was suspended on 7/11/11. The form indicated three residents had made allegations against RN #1 and the Administrator interviewed the residents and they were satisfied with the response to their complaints. The Suspension Form indicated further investigation was initiated by the Division Office and "found that all three residents felt either like they were talked to like a child or demeaned by the tone." The final investigative report, dated 7/15/11, indicated the staff persons comments were inappropriate. The Termination Notice form indicated RN #1 was terminated on 7/15/11, "... for acting indifferently or rudely toward others...."			

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	Although allegations of abuse against RN #1 were received on 6/27/11 and 7/5/11 respectively, there was no documentation the nurse was suspended or that the ISDH was notified regarding the allegations until 7/11/11 (14 days after the first allegation was reported). On 7/25/11 at 2:30 p.m., the Administrator indicated he should have suspended RN #1 and reported the allegations of abuse to the ISDH when they were initially received. The DON (Director of Nursing) indicated that after the allegations were reported, RN #1 worked evenings on the unit where Resident #B, #C, and #D resided. The DON indicated RN #1 worked on 6/28/11, 6/29/11, 6/30/11, 7/1/11, 7/4/11, 7/8/11. 7/9/11 and 7/10/11. The Abuse Investigation Reporting and Response Policy, undated, provided by the Administrator, was reviewed on 7/25/11 at 3:00 p.m., and indicated: "...all alleged violations...which involve mistreatment, neglect, abuse...are reported immediately to the Executive Director of the facility. Such violations will also be reported to State agencies in accordance with existing State law... Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of			

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	punishment, or deprivation. Verbal Abuse: Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents...regardless of age, ability to comprehend, or disability... When an incident or suspected incident of abuse, neglect, or exploitation is reported....(facility must contact the ISDH by telephone... immediately upon determining a situation exists... If the suspected perpetrator is an associate, the Executive Director shall place the associate on immediate investigatory [sic] suspension while completing the investigation... The results of all investigations must be reported to ISDH in writing or by fax, within five (5) working days of the occurrence...." This Federal tag relates to Complaint Number IN00092925 3.1-28(a)			